

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06816

6846

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY CHARLES			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La PLATA.			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La PLATA.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART CONVENT			d. STREET ADDRESS X		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Sister	Middle Agnes	Last Bernard	4. DATE OF DEATH Month June Day 25 Year 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 13, 1899	9. AGE (In years from birthdate) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SISTER OF THE IMMACULATE HEART OF MARY		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		10c. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John CUMMINGS		14. MOTHER'S MAIDEN NAME BRIDGET Gallagher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. NO.		INFORMANT SISTER MARY PAULETTE - La PLATA, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction					
DUE TO 4:30 P.M.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease years					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner) None					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury-spontaneous onset at convent.					
20c. TIME OF INJURY Month, Day, Year Hour 3:15 p.m. June 25 '60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Convent	20f. (City or town) La Plata, Charles, Maryland	(County) (State)
21. I certify that I attended the deceased from 22 May 1960 to 25 June 1960 , that I last saw the deceased alive on 25 June 1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Box 188, La Plata, Md. DATE SIGNED 25 June 1960					
ACTUAL SIGNATURE V.B. Dettor					
PHYSICIAN'S NAME (Type) V.B. Dettor, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/28/60	22c. NAME OF CEMETERY OR CREMATORIUM ST. CATHERINE	22d. LOCATION (City, town, or county) MOSCOW, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Ashland Funeral Home, Inc. La Plata, Md.		ADDRESS 7	24a. REC'D BY REGISTRAR 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

RECORDED STATION NO. 10

UNIVERSITY PARK, PENNSYLVANIA

1970-1971 Academic Year

1971-1972 Academic Year

1972-1973 Academic Year

1973-1974 Academic Year

1974-1975 Academic Year

1975-1976 Academic Year

1976-1977 Academic Year

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

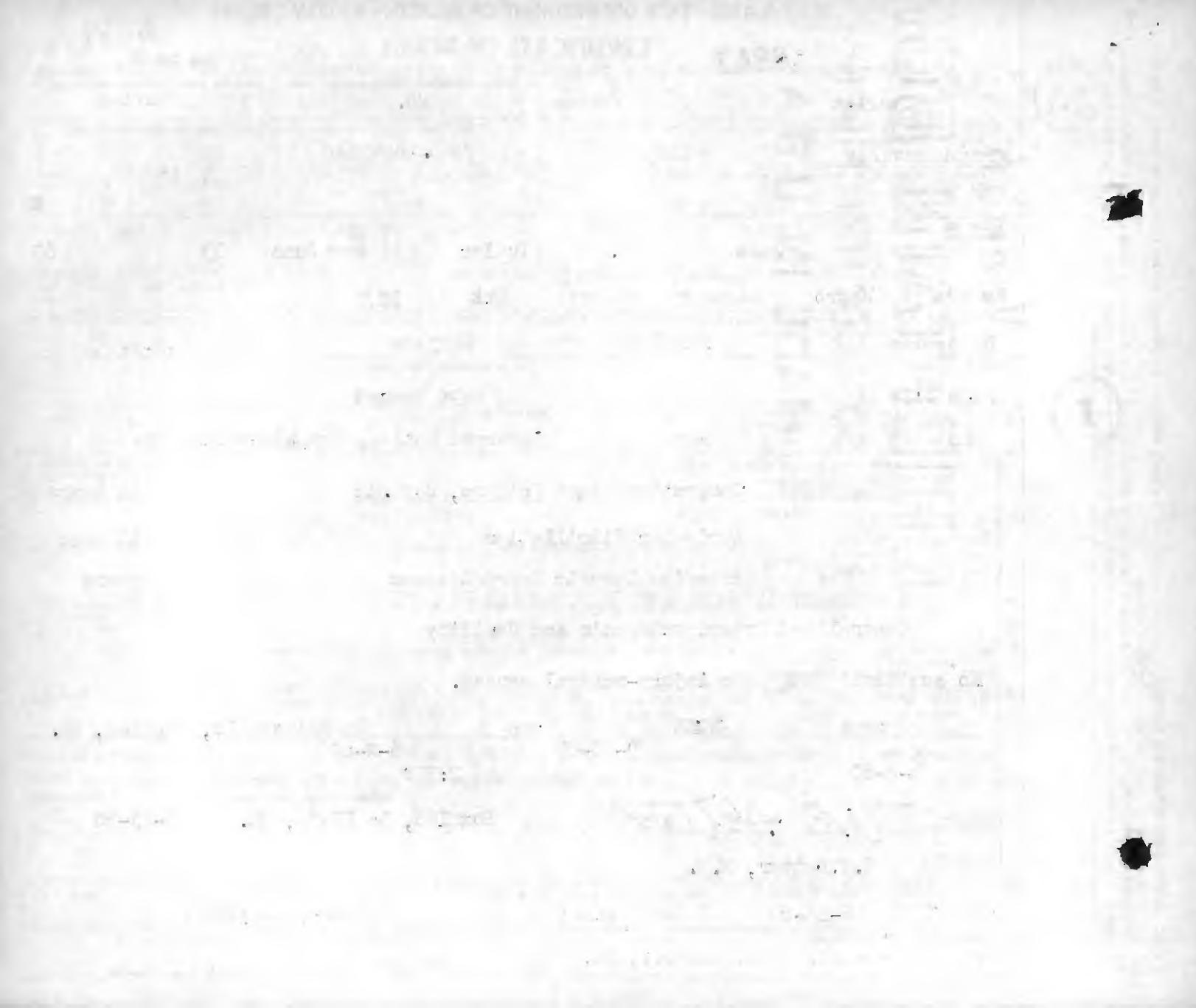
06817

Reg. Dist. No.

6847

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tompkinsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Jane	Middle R.	Last Butler	4. DATE OF DEATH June 13 Month Day Year 19 60
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Unk 1877	9. AGE (in years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min. / / / /
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Slye			14. MOTHER'S MAIDEN NAME Kate Bowman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		INFORMANT Spearman Butler, Tompkinsville, Md.	Address
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Chronic</u> DUE TO <u>450.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular Fibrillation</u> DUE TO <u>450.0</u> 14 days					
(c) <u>Arteriosclerotic Heart Disease</u> years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis and Senility</u> 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF NEITHER, NOTE BY MEDICAL EXAMINER) No accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>No injury-natural causes.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> None	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) Tompkinsville, Charles, Md.	(County) . . (State)
21. I certify that I attended the deceased from <u>9-20-59</u> , 19, to <u>6-2-60</u> , 19, that I last saw the deceased alive on <u>6-2-60</u> , 19, and that death occurred at <u>2:30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 188, La Plata, Md.</u> DATE SIGNED <u>6-13-60</u>					
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D.			
PHYSICIAN'S NAME (Type) V. B. Dettor, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-60	22c. NAME OF CEMETERY OR CREMATORIUM Holy Ghost		22d. LOCATION (City, town, or county) Issue, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 20 '60		24b. REGISTRAR'S SIGNATURE <u>Collier & Haas</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 06818			
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LABLATA				c. LENGTH OF STAY IN 1b Life											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata											
				f. STREET ADDRESS /								g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry Philip Johnson First H Middle P Last J				4. DATE OF DEATH 6 4 1960											
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 22, 1931		9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mess Attendant				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? V.S.A.			
13. FATHER'S NAME Philip Leroy Johnson				14. MOTHER'S MAIDEN NAME Sarah Savoy											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.				17. INFORMANT Austin L. Johnson, La Plata, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 98IX DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c)								Shock ex Interval Hemorrhage 6-4-60 GUNSHOT WOUND REF ABD 6-4-60			
				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot By wife & GUN											
20c. TIME OF INJURY Hour 9 a.m. Month, Day, Year 6-4 1960				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> not at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) La Plata (County) Charles (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE E. Edelen				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 6-4-60			
EXAMINER'S NAME (Type) E. J. EDELEN															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-60		22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart		22d. LOCATION (City, town, county) La Plata		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf Md				ADDRESS				24a. REC'D BY REGISTRAR Arthur S. Kline		24b. REGISTRAR'S SIGNATURE					
								DATE JUN 10 '60							

— ПРОДУКТЫ —
ИТАКО КО СТАРИЛСЯ СДЕЛАТЬ ДЛЯ ТЕБЯ

Сладко

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6849

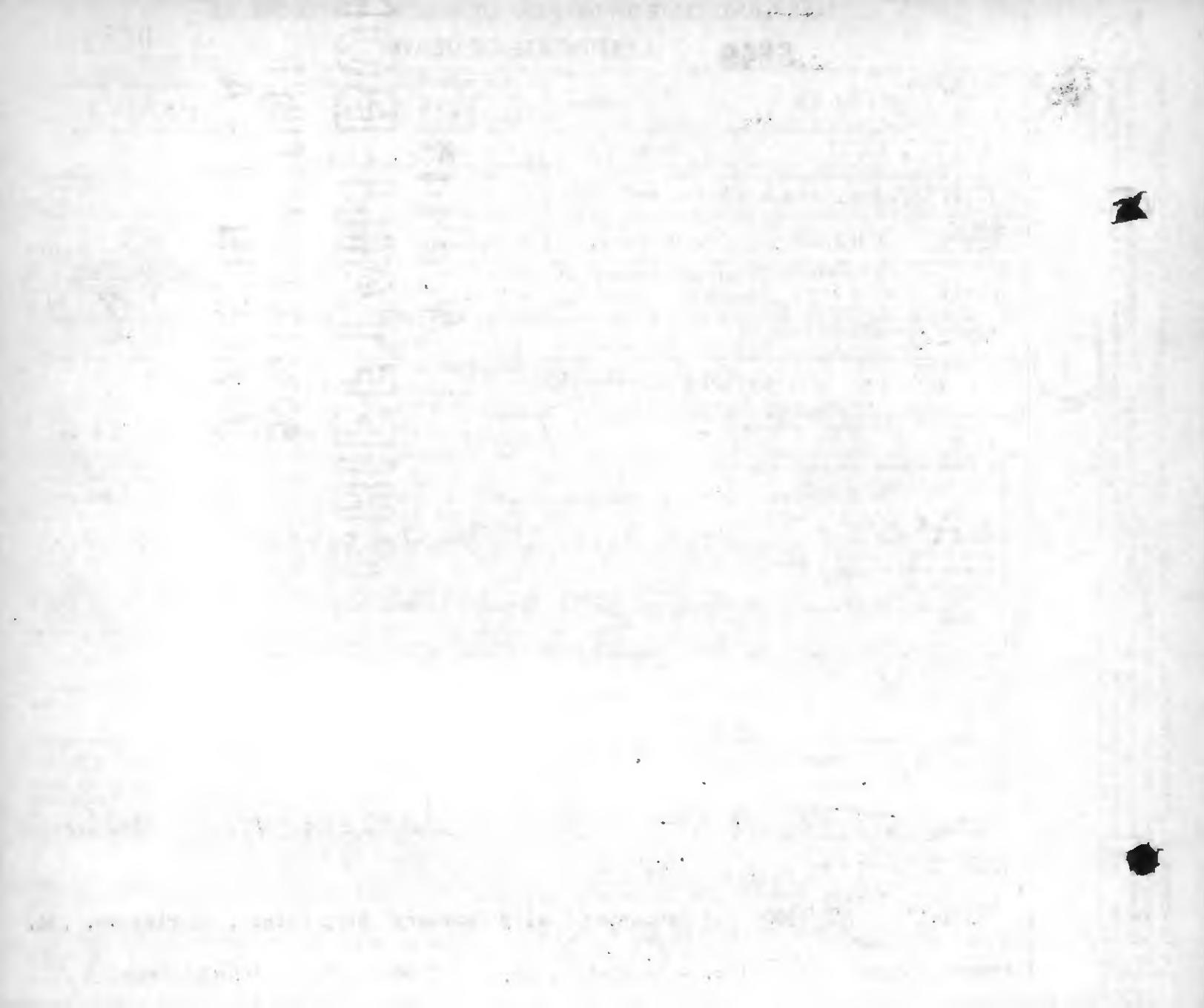
CERTIFICATE OF DEATH

06819

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN lb 1 day.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSPITAL		e. STREET ADDRESS X LA PLATA.	
3. NAME OF DECEASED (Type or print) THOMAS First IGNATIUS Middle LANCASTER		4. DATE OF DEATH JUNE Month 30 Day Year 1960	
S. SEX MALE	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 29 JUNE 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS IGNATIUS LANCASTER		14. MOTHER'S MAIDEN NAME EMMA MARIE BARNES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT THOMAS I. LANCASTER, LA PLATA		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory collapse</i> DUE TO <i>774X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prematurity, 7 months gestation</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 min.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>29 June 1960</i> to <i>30 June 1960</i> , that I last saw the deceased alive on <i>30 June 1960</i> , and that death occurred at <i>9:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur O. Wooldy.</i>		ADDRESS (Street, city or town, state) LA PLATA, MD DATE SIGNED <i>30 June 60</i>	
PHYSICIAN'S NAME (Type) ARTHUR O. WOOLDDY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1960	
22c. NAME OF CEMETERY OR CREMATORIAL Lancaster Family Cemetery		22d. LOCATION (City, town, or county) Rock Point, Charles Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Archart J.C. Echoles Jr.		ADDRESS	
Archart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06826

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. File page 4 to burial cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Chesapeake)</i>		c. LENGTH OF STAY IN lb <i>12 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>King Charles Motel</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Scarsdale</i>	
3. NAME OF DECEASED (Type or print) <i>Hernan F.</i>		f. STREET ADDRESS <i>10 East Parkway</i>	
		g. DATE OF DEATH <i>10-17-78</i>	h. MONTH <i>Oct</i>
		i. DAY <i>6</i>	j. YEAR <i>1960</i>
k. IF UNDER 1 YEAR Months Days Hours Min.		l. IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <i>2-17-78</i>	
9. AGE (In years less birthday) <i>8 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bldg. Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>New York City, N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Lappe</i>		14. MOTHER'S MAIDEN NAME <i>Teresa Radley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>084-01-2418</i>	
17. INFORMANT <i>Mrs. Katherine J. Heuer</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Gen. Art Sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE</i> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN K.D.</i>		DATE SIGNED <i>6-2-60</i>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/6/1960</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Kenisco Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Westchester, New York</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehart Funeral Home, Inc.</i>		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
ADDRESS <i>La Plata, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

AT SIGNUM-BYRON POLYGRAPHIC STATE ONE YEAR
RTA 40 TO STATE TWO 2' RIVMAX JACK-40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

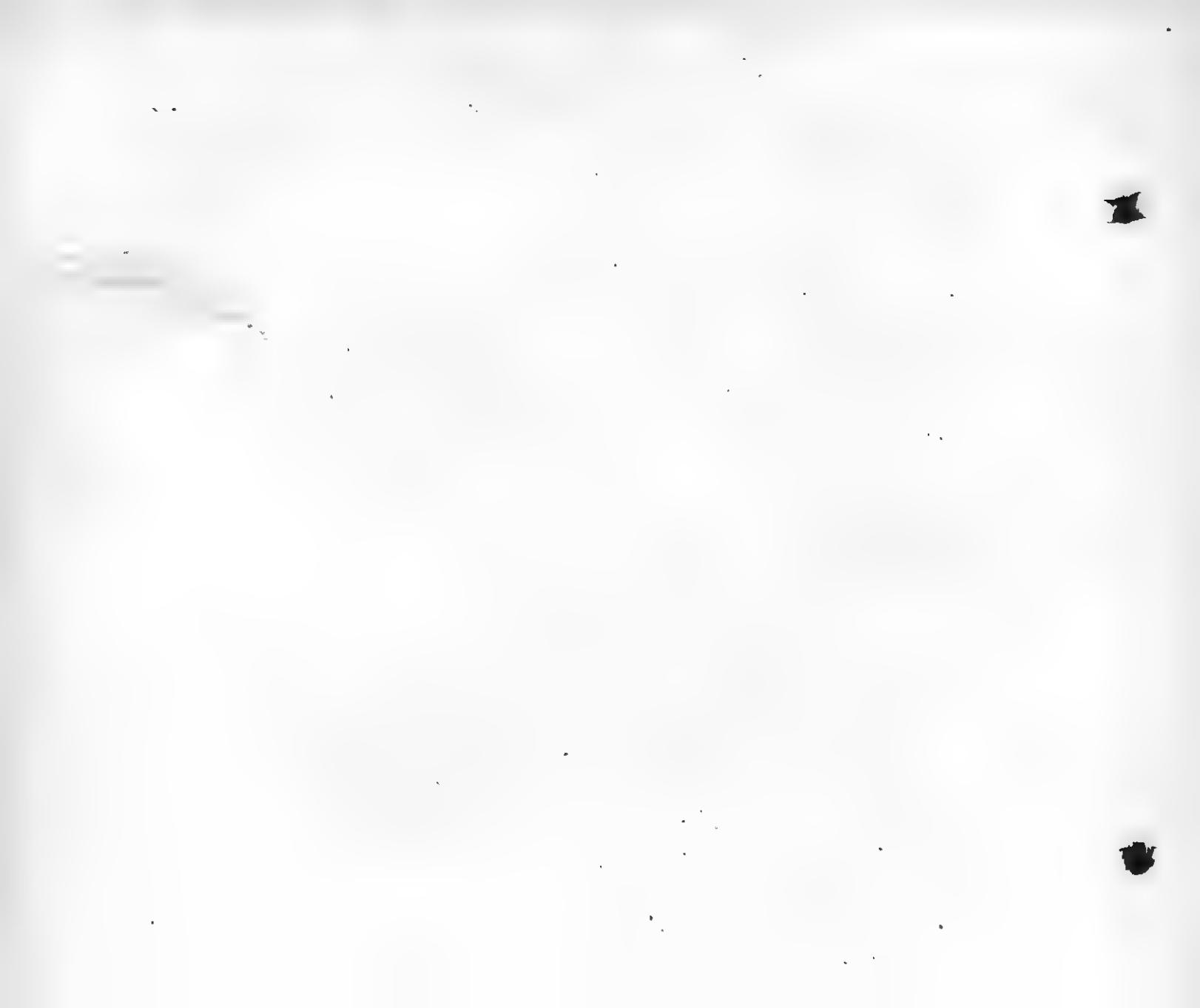
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6851

CERTIFICATE OF DEATH

Reg. Dist. No. 66821

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. LENGTH OF STAY IN lb Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician Mental Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural. La Plata, Md.	
3. NAME OF DECEASED (Type or print) MARVIN		d. STREET ADDRESS 1	
4. SEX Male	5. COLOR OR RACE US-W	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH April 5, 1900
8. AGE (In years last birthday) 60	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0	11. Year 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AG.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. LYON		14. MOTHER'S MAIDEN NAME MARY PADGETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-36-6160	
17. INFORMANT HAROLD LYON, LAPLATA, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cancerous prostate in metastasis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1960 to 28 June 1960 , that I last saw the deceased alive on 28 June 1960 , and that death occurred at 11:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. O. Woody		ADDRESS (Street, city or town, state) LAPLATA	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY		DATE SIGNED 29 June 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-30-60	
22c. NAME OF CEMETERY OR CREMATORIUM Mt Rest		22d. LOCATION (City, town, or county) Lapla, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE JUL 1 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6852

CERTIFICATE OF DEATH

0682

1 PLACE OF DEATH a. COUNTY Charles		2 USUAL RESIDENCE (Where deceased lived. If institution Res. before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c LENGTH OF STAY IN lb Life	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	
		d STREET ADDRESS /	
		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First William	Middle J.
Last Lyon		4. DATE OF DEATH June 13 1960	Month Day Year
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1887
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		9 AGE (in years last birthday) 72 yrs	
13. FATHER'S NAME G. Webster Lyon		14. MOTHER'S MAIDEN NAME Mary Agnes Dudley	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16 SOCIAL SECURITY NO. 217-32-0632	17 INFORMANT Mrs. George Matthews, Hughesville, Maryland
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANEURYSM, ABDOMINAL AORTA		4 YRS. 2 MO.	
4 SIX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DISSECTING RUPTURE, AORTIC ANEURYSM		12 hours	
DUE TO DUE TO (c) GENERALIZED ARTERIO-SCLEROSIS		12 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from SEPTEMBER 1947 to JUNE 13, 1960 , that (I) (we) last saw the deceased alive on JUNE 13, 1960 , and that death occurred at 14 M. from the causes and on the date stated above.		22b DATE SIGNED 6/15/60	
22a SIGNATURE John H. Griffin		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS Hughesville, Maryland
22c. PHYSICIAN'S NAME (Type) John H. Griffin			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6-16-60	23c NAME OF CEMETERY OR CREMATORIAL St Marys	23d. LOCATION (City, town, or county) Bryantown, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		ADDRESS	25a REC'D BY REGISTRAR DATE JUN 20 '60
			25b. REGISTRAR'S SIGNATURE Clayton S. Thomas



06823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6853
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO AETIETY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please ever
 close the certificate, writing the word "pending" in pencil in Item 18. Give Logs 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar
 for burial, cremation, or removal.

VS. A1SME(5)
 5M 9/55

1. PLACE OF DEATH a. COUNTY		C. H. Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE MARYLAND b. COUNTY CHARLES	
MARYLAND POINT		12 years +		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				f. STREET ADDRESS P.O. Box 130 - NANjemoy	
3. NAME OF DECEASED (Type or print)		First JAMES	Middle H	Last MANDLEY	4. DATE OF DEATH Month 6 Day 25 Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1879	9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY FARMER - RETIRED SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME CHARLES		14. MOTHER'S MAIDEN NAME VIENNA WEEKS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT W.B. MANDLEY-(See 2d.) - SON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address INTERVAL BETWEEN ONSET AND DEATH 6-25-60			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		976 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <input type="checkbox"/> DUE TO <input type="checkbox"/> (c)			
976 DUE TO <input type="checkbox"/> DUE TO <input type="checkbox"/> (c)		Greatest wound of head			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Self inflicted			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 6-15 1960		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> or work <input checked="" type="checkbox"/> or home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Point Cedar Hill	
(County) Chesapeake		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE E.J. Edelen		DATE SIGNED 6-25-60			
EXAMINER'S NAME (Type) E.J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-28-1960		22d. LOCATION (City, town, or county) (State) Smyrna, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, Inc. 317 Ph. Ave., S.E. DC 3		ADDRESS Cedar Hill		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
				24b. REGISTRAR'S SIGNATURE Clyde S. Evans	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Items 1 and 2 with the records.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0682.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Md. b. COUNTY Charles				
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Waldorf		c. LENGTH OF STAY IN lb		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] X Waldorf		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ida		First	Middle Maria	Last Pinkney	4. DATE OF DEATH	Month June	Day 13	Year 1960
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1889		9. AGE <small>In years In months In days</small> 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Dent				14. MOTHER'S MAIDEN NAME Maria ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-16-1096		17. INFORMANT Clarence Pinkney, Waldorf, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH 5 min.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>Arteriosclerotic Heart Disease</u>						years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <u>After walking ½ mile, collapsed and expired.</u>						
20c. TIME OF INJURY Month, Day, Year 7:15 p.m. 6-13 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Waldorf, Charles, Md.		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6-13-60		
EXAMINER'S NAME (Type) V.B. Dettor, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-60		22c. NAME OF CEMETERY OR CREMATORIAL St Peters		22d. LOCATION (City, town, or county) Waldorf, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>C. Hunt & Son</i>	
						JUN 20 '60		



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 66825

1. PLACE OF DEATH a. COUNTY Charles MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Hilltop/Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hilltop		d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First John	Middle Francis	Last Proctor	4. DATE OF DEATH June 12	Month Year 1960
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1934	9. AGE (In years last birthday) 25 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General Construction		11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Proctor	14. MOTHER'S MAIDEN NAME Rosetta Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-36-8866	17. INFORMANT Mr. James E. Proctor, Hilltop, Maryland	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH 37 hrs.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage			
DUE TO (b) Head Injury in auto accident			37 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I(a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto racing on Rt. 225, car overturned		
20c. TIME OF INJURY 2:30 p.m.	Month, Day, Year 6-11 '60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) La Plata, Charles, Md.	(County)	(State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
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ACTUAL SIGNATURE <i>V.B.Dettor</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 6-13-60
EXAMINER'S NAME (Type) V.B.Dettor, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Act.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-18-60	22c. NAME OF CEMETERY OR CREMATORIUM Church	22d. LOCATION (City, town, or county) Granville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. D. Bear 1735 - 15th St. N.W.	ADDRESS	24a. REC'D BY REGISTRAR JUN 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrars or removal.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be referred to your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6856 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06826

1. PLACE OF DEATH

a. COUNTY

Charles
Benedict

MARYLAND

b. CITY OR TOWN (If outside corporate lims., write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b
NAME OF HOSPITAL OR INSTITUTION (if not in hospita., give street address)

Transient

Patuxent River Bridge

3. NAME OF
DECESSED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
6

Day
3

Year
1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
47 yrs.

10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done, or kind of work done, even if reman-
tobacco Farming --- Own Farm

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Maryland

14. MOTHER'S MAIDEN NAME

Charles L. Richardson

Alma Canter

15. WAS DECEASED EVER IN U.S. ARMED FORCES

16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give rank or grade of service)

17. INFORMANT

Address

Marie Louise Richardson-Brandywine, Md.

INTERVAL BETWEEN
ONSET AND DEATH
8-3-60

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Condition, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

Drowning

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
6-3 1960

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
River

20f. CITY OR TOWN
Benedict CHAS 13d-

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

J.M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-5-60

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF
St. Paul's Cemetery

22d. LOCATION (City, town, or county)
Beden,

(State)

Burial 6/7/60

ADDRESS
Upper

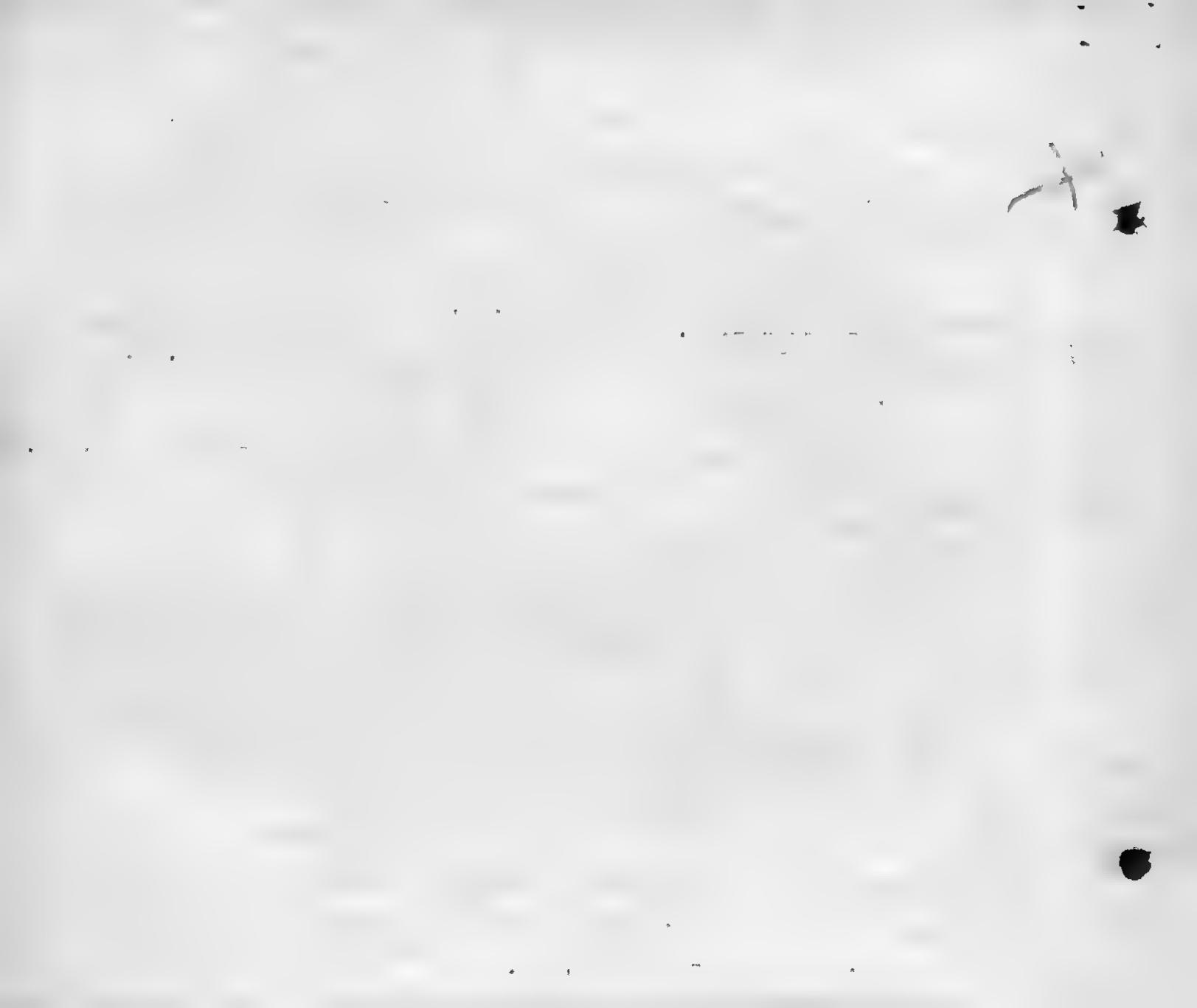
24a. REC'D BY REG STRAR
JUN 14 '60

Md.

23. FUNERAL DIRECTOR

Ritchie Bros. Fun'l Home-Marlboro, Md.

24b. REGISTRAR'S SIGNATURE
Arthur J. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6857

CERTIFICATE OF DEATH

0682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md., b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomonkey	c. LENGTH OF STAY IN 16 83 yrs	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pomonkey	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS RFD #2 LaPlata		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) G. L. S.	First Thomas	Middle	Last
4. DATE OF DEATH Month 11 Day 1 Year 1960			
5. SEX M	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Mar '77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger	10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov	11. BIRTHPLACE (State or foreign country) D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frederick SLATER	14. MOTHER'S MAIDEN NAME Jane CAMPBELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 215-36-5621	17. INFORMANT Mr. Rebecca SLATER	Address Stur Rt #2 LaPlata, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 1420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 3. Ca of Bladder (remote)			
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas G. Shultz M.D. R.V. 1, Box 700 11 Jul 1960			
PHYSICIAN'S NAME (Type)			
22a. BUR AL. CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7-18-66	22c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Methodist	22d. LOCATION (CITY, TOWN, OR COUNTY) (State) Pomonkey, Md
23. FUNERAL DIRECTOR'S SIGNATURE Barney & Matthews 3619-14 "87" 205 Wash DC		24a. REC'D BY REGISTRAR DATE JUN 14 '60	24b. REGISTRAR'S SIGNATURE Oliver S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06828

6858

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Charles

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)

o. STATE

Md.

b. COUNTY

Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

c. LENGTH OF STAY IN 1b

d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Popes Creek

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Physicians Memorial

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

TURNER

JUNE

25

1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
(last birthday)
yrs

IF UNDER 1 YEAR IF UNDER 24 HRS

Male

Negro

WIDOWED DIVORCED

May

1904

Months

Days

Hours

Min.

10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11 BIRTHPLACE (State or foreign country)

Maryland

12 CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas William Turner

14. MOTHER'S MAIDEN NAME

Harriet Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

INFORMANT

Mary Yates, Newburg, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)177X
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.
DUE TO
(b)
DUE TO
(c)Carcinoma of the Prostate c
MetastasesINTERVAL BETWEEN
ONSET AND DEATH

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1958 to 6-25-1960, that I last saw the deceased alive on 6-25-1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John Johnson

M.D.

La Plata

Md. 6-25-60

PHYSICIAN'S
NAME (Type)

F. M. Sonnen MD

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

6-29-60

22b. DATE THEREOF

St Ignatius

22c. NAME OF CEMETERY OR CREMATORIUM

Bel Alton, Md.

(State)

22d. LOCATION (City, town, or county)

23. FUNERAL DIRECTOR'S SIGNATURE

The Huntt Funeral Home, Waldorf, Md.

ADDRESS

RECD BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

C. Miller



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
6859				CERTIFICATE OF DEATH									
				06829 Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural La Plata c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY DAVIDSON TURIVER First MARY Middle DAVIDSON Last TURIVER				4. DATE OF DEATH Month 6 Day 20 Year 1960									
5. SEX F 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1869		9. AGE (in years last birthday) yrs. 90		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Wilson Davison				14. MOTHER'S MAIDEN NAME Sophia Bond									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Maxwell Mitchell, La Plata, Maryland		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CARDIO VASCULAR RENAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 782.4 DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)					
21. I certify that I attended the deceased from 7 , 19 60 , to 6-20 1960 , that I last saw the deceased alive on 6-11 1960 , and that death occurred at 8A.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. E. J. Edelen M.D. PHYSICIAN'S NAME (Type) J. E. J. Edelen ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 6-22-60													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-60		22c. NAME OF CEMETERY OR CREMATORIUM Louden Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland						ADDRESS		24a. REC'D. BY REGISTRAR DATE JUN 27 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
VS A15 (4) 15M 9/55													

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06830

6860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remember to file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First William	Middle Cleveland	Last Vernon	4. DATE OF DEATH June	Month 27	Day 19	Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 26, 1886		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Lee Vernon			14. MOTHER'S MAIDEN NAME Isabell Hamilton								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James Vernon, Indian Head, Maryland		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 502 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) Chronic Bronchitis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy with obstruction & Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (N.B. THE COULD BE EXAMINER) No accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury		20c. TIME OF INJURY Month, Day, Year Hour 0 m 19			20d. INJURY OCCURRED White Not white of work work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Onset at home	20f. (City or town) Waldorf, Charles, Maryland	(County)	(State)
21. I certify that I attended the deceased from 1-1-60, 19, to 4-30-60, 19, that I last saw the deceased alive on 4-30-60, 19, and that death occurred at 4:15P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Box 188, La Plata, Md.			DATE SIGNED 6-28-60		
ACTUAL SIGNATURE V.B. Dettor		PHYSICIAN'S NAME (Type) V.B. Dettor, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-60		22c. NAME OF CEMETERY OR CREMATORIUM St Pauls		22d. LOCATION (City, town, or county) Waldorf, Maryland			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland						24a. REC'D BY REGISTRAR DATE JUN 1 '60	24b. REGISTRAR'S SIGNATURE C. B. Hunt				
VS A15 (4) 1SM 9/55											

CERTIFICATE OF DEATH

RECEIVED

RECORDED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED